Summary of BlueCare HMO Benefits

Offered through Health Options, Inc., a subsidiary of Blue Cross and Blue Shield of Florida

Lake County BCC

Physician Office Services	
Primary Care Physician (PCP)	$20 Copay
Participating Specialist	$35 Copay
Surgery in Physician's Office	PCP or Specialist Copay
Well Child Care	$0 Copay
Maternity (Initial Obstetrician Visit Only)	$20 Copay
Additional Services (Office or Outpatient Facility)	
Allergy Injection (including serum)	$0 Copay
Allergy Testing	PCP or Specialist Copay
Diagnostic Lab and X-ray	PCP or Specialist Copay
Hospital/Free Standing Facility:	
Lab and X-ray	$15 Copay
MRI, CS, Endo, Stress	$200 Copay
Outpatient Physical, Speech, or Cardiac	$20 Copay (calendar year maximum of 62 consecutive days)
Occupational Therapy	$20 Copay ($200 calendar year maximum)
Spinal Manipulations	$20 Copay ($500 calendar year maximum)
Inpatient Services	
Inpatient Hospital	$200 Copay per day up to $1,000 per admission
Inpatient Physician	$0 Copay
Inpatient Rehabilitation Services (e.g., Physical, Speech, Cardiac, or Occupational)	$0 Copay
Outpatient Services	
Outpatient Hospital or Ambulatory Surgical Center	$200 Copay
Dialysis	$0 Copay
Birthing Center	$0 Copay
Emergency Services and Care (Copay Waived if Admitted)	
Emergency Room in a Contracting Hospital	$100 Copay
Emergency Room in a Non-Contracting Hospital	$100 Copay
Ambulance (Medically Necessary)	$0 Copay
Other Services	
Durable Medical Equipment	$0 Copay
Home Health Care	$0 Copay (subject to a 40 day calendar year maximum)
Hospice	$0 Copay ($5,000 lifetime maximum)
Independent Diagnostic Testing Facility	
Diagnostic Testing	Specialist Copay
Radiology	$0 Copay
Prosthetic and Orthotic Devices	$0 Copay
Skilled Nursing Facility (90 Days per Calendar Year)	$0 Copay
Second Medical Opinion	
Services Rendered by a Contracting Provider	Specialist Copay
Services Rendered by a Non-Contracting Provider	Member pays 40% of allowance and balance billing may occur
Urgent Care Center	$30 Copay
Bereavement Counseling	$0 Copay (6 visits/$250 lifetime maximum)
Wig after Chemotherapy	$0 Copay
Infertility Services	
Primary Care Physician (PCP) - Diagnosis Only	PCP Copay
Participating Specialist – Diagnosis Only	Specialist Copay
Mental Health/Substance Abuse	Covered through Bradman Unipsych
Maximum Copayments per Calendar Year	
Individual	$2,000
Family Aggregate	$4,000
Lifetime Maximums Per Insured	
Total	$2,000,000
Pre-Existing Conditions	Covered after 12 months
Prescription Drugs	
Retail (One month, includes Oral Contraceptives)	
Generic Drugs	$ 15 Copay
Preferred Brand Drugs	$ 25 Copay
Non-Preferred Brand Drugs	$ 40 Copay
Mail Order (90 days, includes Oral Contraceptives)	
Generic Drugs	$ 30 Copay
Preferred Brand Drugs	$ 50 Copay
Non-Preferred Brand Drugs	$ 80 Copay

All health care services must be provided by or authorized by your Primary Care Physician (PCP). This is a Summary of Benefits and not a contract. All benefits are subject to the provisions, exclusions, and limitations set forth in the master policy.

Summary of BlueChoice PPO Physician Copayment Benefits

Lake County BCC

Deductibles	
Individual Calendar Year Deductible	$750
Family Aggregate Calendar Year Deductible	$2,250
Emergency Room Per Visit Deductible (All Hospitals)	$50
Note: The calendar year deductible is waived for independent clinical laboratory services.	
Coinsurance Percentage Payable by BCBSF	
PPO Providers - Allowed Amount	80%
Non-PPO Providers - Allowed Amount	60%
Ambulance Services	80%
Maximum Out of Pocket Coinsurance Responsibility Per Calendar Year	
Individual Coinsurance Limit	$2,000
Family Aggregate Coinsurance Limit	$6,000
Note: Maximum out of pocket coinsurance responsibility limits do not include any deductibles, copays, any benefit penalty reduction, non-covered charges or any charges in excess of the allowed amount.	
Office Services	
PPO Family Physicians (Family Practice, General Practice, Internal Medicine, or Pediatrics)	$20 Copay
Other PPO Providers	$35 Copay
Allergy Injections	$0 Copay
Allergy Testing	$20 Family Physician or $35 Specialist Copay
Non-PPO Providers	Calendar Year Deductible and Coinsurance
Note: Durable medical equipment, prosthetics, and orthotics are not subject to the copay requirement, but are subject to the individual calendar year deductible and coinsurance responsibility.	
Calendar Year Maximums Per Insured	
Mental Health / Substance Abuse Services	Covered through Bradman Unipsych
Home Health Care	$5,000 per calendar year
Skilled Nursing Facility Days	90
Low Protein Food Products	$2,500
Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies	All therapies: 60 visits combined
Spinal Manipulations	($500 calendar year maximum)
Lifetime Maximums Per Insured	
Total	$2,000,000
Hospice Benefit	$5,000
Bereavement Counseling	6 visits/$250 lifetime maximum
Additional Benefits	
Independent Diagnostic Test Facility	
PPO Providers	Specialist copay
Non-PPO Providers	Calendar Year Deductible and Coinsurance
Mammogram Screening Services	Covered at 100% of Allowed Amount.
Maternity	
In-network:	$20 Initial Copay, then covered at 100%
Out-of-network	Covered at 60% after deductible
Infertility	Diagnosis Only
In-network:	80% after calendar year deductible
Out-of-network:	60% after calendar year deductible
Transplant Services	Heart, heart-lung combination, liver, kidney, cornea and bone marrow transplants.
Well Child Care	
In-network:	Covered at 100% after office visit copay; Birth to age 16, deductible waived.
Out-of-network:	Covered at 60%; Birth to age 16, deductible waived.
Wellness Benefit (Adults)	Covered services for an adult (age 17 and over) include an annual exam and related wellness services up to a calendar year maximum of $200. These services are not subject CYD, but are subject to the applicable copay or coinsurance responsibility. Routine vision and hearing examinations are not covered. Mammograms do not accumulate to the calendar year maximum.
Vaccinations Covered (including Flu Shots)	
Pre-Existing Conditions	Covered after 12 months.
Urgent Care Center	
PPO Providers	PPO Family Physician copay
Non-PPO Providers	Calendar Year Deductible and Coinsurance
Wig after chemotherapy	Calendar Year Deductible and Coinsurance

Prescription Drugs	
Retail (One month, includes Oral Contraceptives)	
Generic Drugs	$ 15 Copay
Preferred Brand Drugs	$ 25 Copay
Non-Preferred Brand Drugs	$ 40 Copay
Mail Order (90 days, includes Oral Contraceptives)	
Generic Drugs	$ 30 Copay
Preferred Brand Drugs	$ 50 Copay
Non-Preferred Brand Drugs	$ 80 Copay

This is a summary of benefits and not a contract. All benefits are subject to the provisions, exclusions and limitations set forth in the master contract. This plan provides coverage for certain physician office services, without having to satisfy a calendar year deductible requirement, when obtained from a PPO physician. To verify a provider's specialty or participation status, the insured may contact the local BCBSF office, contact the provider's office, or review the most recent provider directory. It is the insured's sole responsibility to select and verify a provider's network participation status at the time services are rendered.